HUMANITARIAN NEEDS EVALUATION FOR VICTIMS OF THE NAGORNO-KARABAKH CONFLICT

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EXECUTIVE SUMMARY

Across the southern Caucasus region encompassing Armenia and Azerbaijan (including the territory of Nagorno-Karabakh), there is no acute and widespread humanitarian crisis affecting the victims of the Nagorno-Karabakh conflict. The situation of those affected by the conflict has generally stabilized with respect to food security, shelter, and medical services. While problem areas clearly remain and some groups are in need of continuing relief assistance, the general situation is evolving such that improving shelters and generating income producing activities may be the most useful areas for intervention.

ARMENIA

There is no acute humanitarian crisis in Armenia among victims of the Nagorno-Karabakh conflict. Conflict victims are affected by the same impoverishment suffered by the majority of the general population, although in many cases they endure inferior shelter conditions. A significant number of refugees of urban origin face challenges in the rural settings where they have been relocated. Conflict victims, whether classified as refugees or Nagorno-Karabakh Armenians, suffer legal status problems. Non-displaced Armenians residing in the districts along the northern border with Azerbaijan continue to be directly affected by the conflict, as cross-border hostilities have reportedly compounded the challenges posed by inherently limited economic opportunities and lack of central government assistance. Somewhere between 2-5,000 families from Nagorno-Karabakh remain in Armenia, awaiting the rehabilitation of suitable shelter which would allow them to return home.

Recommendations

1) Review conditions in the northern border districts to determine whether additional humanitarian assistance is called for.

2) Review shelter conditions and assistance for refugees to determine whether adequate resources are available for critical needs.

NAGORNO-KARABAKH

There is no acute humanitarian crisis in Nagorno-Karabakh. The region's small population (estimated to be near 130,000) includes limited numbers of potentially vulnerable people (+/- 5,000), principally those in the most seriously damaged conflict areas, some elderly without family, and large families without a breadwinner. The least well-off unemployed in urban areas are another potentially vulnerable group, although no evidence of systematic need has been found. There is a strong local administration which appears to well connected to the needs of the community.

Recommendations

Humanitarian assistance effort to Nagorno-Karabakh should:

1) Focus on rehabilitation of damaged shelter to allow return of displaced persons.

2) Assess the existing immunization program, logistics and long-term vaccination supply.

3) Increase health awareness especially around Maternal Child Health (MCH) issues and make health education and medical resource materials available at different levels within the health system.

4) Support ICRC initiatives to train medical personnel in appropriate strategies for long-term home care.

5) Support efforts to re-train warehouse managers in pharmaceutical distribution, storage and pro-active planning to meet seasonal changes in demand.

6) Support ICRC's medical assessment of the current health status for the whole population, and train health care workers in use of medicines and implementation of protocols.

7) Support the establishment of a comprehensive system of psycho-social or psychiatric care, capacity-building among local practitioners, and introduction of "new" out-patient or community-based methods such as work therapy.

8) Support small-scale enterprise and agricultural production activities to improve the economic condition of those most affected by the conflict.

AZERBAIJAN

There is no acute humanitarian crisis in Azerbaijan among victims of the Nagorno-Karabakh conflict. Conflict victims are affected by the same impoverishment suffered by the majority of the general population, although in most cases they endure inferior shelter conditions. Azeris residing in the districts along the northern border with Armenia continue to be directly affected by the conflict, as cross-border hostilities have reportedly compounded the challenges posed by inherently limited economic opportunities and lack of central government assistance. Some 600,000 internally displaced persons (IDPs), in varying conditions and with varying capacities to provide for themselves, remain a serious economic and political burden on a country struggling with post-Soviet economic deterioration.

Recommendations

1) Review conditions in the northern border districts to determine whether additional humanitarian assistance is called for to the most vulnerable in those areas.

2) Give priority to improving shelter conditions for IDPs.

3) Continue support for pilot income-generating activities that enable families, inter alia, to pay for health care services.

4) Support wider dissemination of health educational and medical resource materials such as MSF standard medical protocols in Russian, IRC's Azeri translation of "Where There is No Doctor" and other USAID supported publications on MCH including breast feeding, immunization and safe motherhood.

5) Increase support from the international community to implement WHO protocols for communicable diseases such as TB and malaria.

CONTENTS

			Page
i.	Executive Summary		i.
ii.	Matrix		iv.
iii.	Maps		vii.
I.	Introduction		1
II.	Armenia		3
	Conclusions and Recommendations		
	Findings		
III.	Nagorno-Karabakh		6
	Conclusions and Recommendations		
	Findings		
V.	Azerbaijan		15
	Conclusions and Recommendations		
	Findings		
IV.	Potential Program Opportunities		22
V.	Annexes		
	A.	Field Notes, Nagorno Karabakh	25
	B.	Notes, Public Health	33
	C.	Contacts	41
	D.	Scope of Work	45

Links to Tables and Graphics: Click on the buttons below:

HUMANITARIAN NEEDS EVALUATION FOR VICTIMS OF THE NAGORNO-KARABAKH CONFLICT COMPARATIVE MATRIX

NAGORNO-KARABAKH MAP

ARMENIA AND AZERBAIJAN MAP

ABBREVIATIONS

N-K	**Nagorno-Karabakh**
ICRC	**International Committee of the Red Cross**
NGO	**Non-Governmental Organization**
IDP	**Internally Displaced Person**
EPI	**Expanded Programme of Immunization**

INTRODUCTION

A three person team of independent consultants spent two weeks in the Caucasus, traveling to Armenia, the Nagorno-Karabakh region, henceforth referred to only as "Nagorno Karabakh", and the rest of Azerbaijan. The team consisted of a public health specialist, a regional specialist, and a development planner.[1] Following briefings from USAID and State Department officials, the team departed Washington on the 16th of January, arriving in Yerevan on the evening of the 17th. The team returned to the United States on the 31st of January.

The two weeks spent in the Caucasus were allocated as follows:

January 17th to the 20th in Yerevan, Armenia;

January 21 to 26 in Nagorno-Karabakh ;

January 26 to 31 in Azerbaijan.

The team's mission was to carry out an evaluation of the humanitarian assistance needs for refugees, displaced persons, and needy civilians affected by the Nagorno-Karabakh conflict. A full copy of the team's Scope of Work is attached in an Annex.

A major focus of the team's work was to assess vulnerable populations among victims of the Nagorno-Karabakh conflict. For purposes of this evaluation, a working definition of 'vulnerable' was determined to be populations at risk due to one or more of the following conditions: food insecurity; inadequate shelter, water, or sanitation; lack of access to health care; and/or exposure to land mines or unexploded ordnance.

The major focus of this evaluation was Nagorno-Karabakh and the rest of Azerbaijan. Time spent in Armenia and contacts with humanitarian agencies were limited at the request of US Embassy/Yerevan. Much of the work of the team in Armenia was devoted to internal discussions with USAID and Embassy personnel, with logistical arrangements to allow the team to proceed to Nagorno-Karabakh, and meetings with a few organizations already active in assistance to Nagorno-Karabakh. For these reasons, this report says relatively little about the situation of conflict victims inside Armenia proper.

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[1] The public health specialist on the team was Kirsti Lattu; the regional specialist was Dennis Culkin; the development planner was David Garner.

The assessment methodology followed by the team involved field visits and interviews with various levels of officials, international and bilateral donor agency staff, non-governmental organization (NGO) staff and local people. Typically the team began in the capital city, worked out to local leaders, and then visited a limited number of selected villages, internally displaced person (IDP) camps, and/or medical facilities. The team made periodic unannounced visits and stops along the way, to get as realistic a picture of the overall situation as possible.

The authorities in Nagorno-Karabakh and the staff of various international agencies and NGOs working in all three areas visited went out of their way to help the team understand the magnitude and complexities of the problems confronting the victims of the Nagorno-Karabakh conflict.

ARMENIA

Conclusions

There is no acute humanitarian crisis in Armenia among victims of the Nagorno-Karabakh conflict. Conflict victims are affected by the same impoverishment suffered by the majority of the general population, although in many cases they endure inferior shelter conditions. A significant number of refugees of urban origin face challenges in the rural settings where they have been relocated. Conflict victims, whether classified as refugees or Nagorno-Karabakh Armenians, suffer legal status problems. Non-displaced Armenians residing in the districts along the northern border with Azerbaijan continue to be directly affected by the conflict, as cross-border hostilities have reportedly compounded the challenges posed by inherently limited economic opportunities and lack of central government assistance. Somewhere between 2-5,000 families from Nagorno-Karabakh remain in Armenia, awaiting the rehabilitation of suitable shelter which would allow them to return home.

Recommendations

1) Conditions in the northern border districts should be reviewed to determine whether additional humanitarian assistance is called for. Specific concern has been raised about water and sanitation issues for Novembrian, Idjevan, and Taush.

2) Shelter conditions for refugees should be reviewed to determine whether adequate resources are available for critical needs.

3) Support should be given to UNICEF in addressing the psyco-social needs of children in the border areas through training teachers in psycho-social support for children exhibiting signs of stress.

4) Appropriate steps should be taken to encourage the Government of Armenia to extend to refugees in Armenia the benefits of citizenship status legislation already adopted.

Findings

Vulnerable Groups

Economic crisis since the collapse of the Soviet Union has driven the vast majority of Armenians into difficult and sometimes extremely difficult circumstances. In this sense, many Armenians in various categories (single elderly, those in social institutions, earthquake victims, and others) could be said to be vulnerable. This evaluation, however, is focused on the victims of the Nagorno-Karabakh conflict, and all figures on vulnerable populations are limited to this group. Other than to note the more widespread problem, no effort is made here to make specific comparisons between the situation of conflict victims and the socially vulnerable population.

In Armenia, the vulnerable population of Nagorno-Karabakh conflict victims must be considered primarily as some subset of refugees. Of a total registered refugee population of 225,000 in Armenia, UNHCR estimates that 160,000 remain in the country (most of the rest are abroad for employment opportunities). Of these, 15,000 families or some 60,000 people are said to live in very bad shelter conditions. Apart from shelter conditions, location in rural settings --- away from the greater access and economic opportunities of the urban areas --- seems to be the major factor making particular refugees more vulnerable. Approximately 70% of refugees live in rural areas, but no figures are available for identifying those within that percentage who might be more vulnerable due to either shelter conditions or individual economic situations.

Given available information, and also that shelter is the most readily verifiable factor directly affecting the health and welfare of refugees, the 60,000 refugees living in bad shelter may be considered the most vulnerable population among conflict victims. This is approximately 2% of Armenia's population.

In addition to this group, an unknown number of Armenians residing in the northeast border districts, which continue to be affected by the conflict, could be considered part of the vulnerable population.

Public Health

There appears to be a reasonable level of national cooperation between the Ministry of Health, international NGOs and UN agencies to ensure best efforts to improve maternal child health, access to care, and even psychological programs for children. However, unstable border regions are a concern. Interestingly, Yerevan hospitals act as reference hospitals for Nagorno-Karabakh. The Armenian Ministry of Health occasionally provides vaccines and medicines to cover shortages in Nagorno-Karabakh. Thus there appears to be an informal institutional link between the two health authorities.

Food Security

Food security does not appear to be an acute or widespread problem among N-K conflict victims residing in Armenia. However, UNHCR provided anecdotal assessment that some rural refugee children showed signs of malnutrition. UNHCR also stated that the PAROS system, an income-estimation system used to target all humanitarian assistance in Armenia, understated the food aid needs of certain refugee families. UNHCR may seek to have World Food Program (WFP) support to refugees expanded to cover these perceived gaps.

Given the lack of quantitative information on the reported food aid gaps for certain refugee families, it is not possible to make any precise judgement on the subject. It should be noted that chronic malnutrition (prolonged insufficiency of dietary intake), as evidenced by stunting among children, has been observed in Armenia for several years by nutritional surveillance activities covering the general population.

Shelter

The team was constrained by time in Armenia, and did not evaluate the current housing stock for IDPs or refugees. Briefings indicated that perhaps as many as 5,000 families from Nagorno-Karabakh currently are living in Armenia, and would like to return to their place of origin, provided suitable shelter were available.

Water and Sanitation

The team made no visits outside of Yerevan, and was not able to directly investigate water and sanitation issues in Armenia. However from general conversations, the team believes that water and sanitation conditions in Armenia are roughly comparable to the situation in Nagorno-Karabakh and Azerbaijan, which are described below.

NAGORNO-KARABAKH

Conclusions

There is no acute humanitarian crisis in Nagorno-Karabakh. The region's small population (estimated to be near 130,000) includes limited numbers of potentially vulnerable conflict victims, (+/- 4,000), principally those in the most seriously damaged conflict areas, together with invalids from the war, plus some elderly without family, and large families without a breadwinner. The least well-off unemployed in urban areas are another potentially vulnerable group, although no evidence of systematic need has been found. The team's main conclusions:

1) There is a strong local administration in place, which is closely in touch with local needs.

2) Food security is generally assured, in large part due to the self-sufficient agricultural activity in the rural areas, although chronic malnutrition and some stunting among children (typical of the south Caucasus region) are likely to be found.

3) A well-identified and relatively limited number of private dwellings (perhaps 3-5,000) require rehabilitation to allow return of displaced persons and refugees; scattered vulnerable individuals, particularly elderly, are in need of improved shelter. An estimated overall need for shelter is +/- 5,000 units.

4) In Nagorno-Karabakh the public health system suffers familiar post-Soviet ills such as: lack of prevention; health education; outdated protocols; medical under treatment contributing to drug resistance; deteriorating infrastructure and poor distribution or lack of medicines. No current epidemics of serious infectious diseases have been seen. Non-civilian medicine remains the stated N-K authority's priority for medical equipment, trained personnel and financial resources.

5) Children, who comprise more than 20% of the population, [+/- 39,000] are moderately vulnerable due to suspect immunization coverage. Their risk is compounded by the absence of a health system infrastructure that enables early detection or prevention activities beyond immunization.

6) The home-bound war-wounded, including paraplegics, disabled, amputees and paralyzed are a small but potentially vulnerable population.

7) Provision of medicines beyond those aimed at insuring childhood immunizations supply will not be effective assistance at this time due to distribution problems and uncertainties. Private foreign donations of medicines might alleviate drug shortages if management of distribution can be improved.

8) It would be beneficial to explore post-traumatic stress disorder (PTSD), psycho-social or neurological incidence, and to foster establishment of an early detection and referral system.

9) Water and sanitation conditions vary, but appear sufficient to prevent serious outbreaks of enteric illnesses. The few urban water systems are most likely in need of rehabilitation, but reliance on artesian and other good natural sources in most rural areas is an advantage. The authorities expressed no interest in assistance to reconstruct urban water facilities.

10) Fatalities and injuries by land mines and unexploded ordnance continue, but in most locations residents know and avoid hazardous areas, and an internal de-mining capacity (operated by the military is available for a fee in non-strategic areas) exists. The number of victims has declined dramatically in the past 6-12 months, now averaging perhaps a few a month. Significant hectarage of valuable land remains out of production as a consequence of mines and unexploded ordnance, as well as the unsettled condition along the military front. The impact of mines on N-K's dwindling supply of agricultural equipment is significant. Cattle are substantially at risk from mines, with economic consequences.

11) As unemployment spirals and the economy stagnates, small scale income-generation activities and assistance to agricultural production could contribute to addressing the humanitarian needs of the region.

12) Few non-governmental or international organizations are active in providing relief to N-K. Nonetheless, the small population can probably be substantially addressed through these organizations, perhaps augmented by one or two NGOs. This may be particularly true if unknown but presumably substantial Diaspora donations are channeled efficiently to meet priority humanitarian requirements.

13) The villages most affected by the conflict, although suffering some substantial destruction, are relatively cohesive, and their populations are taking active constructive steps to rebuild their lives and reestablish rural economic productivity, within existing constraints.

Recommendations

Humanitarian assistance effort to Nagorno-Karabakh should:

1) Focus on rehabilitation of damaged shelters to allow return of displaced persons.

2) Support an assessment of the existing immunization program, logistics and long-term vaccination supply.

3) Increase health awareness especially around Maternal Child Health (MCH) issues and understanding standard medical protocols and make health education and medical resource materials available at different levels within the health system.

4) Support ICRC initiatives to train medical personnel in appropriate strategies for long-term home care of war-wounded and home-bound.

5) Support re-training of warehouse managers in pharmaceutical distribution, storage and pro-active planning to meet seasonal changes in demand.

6) Support ICRC's proposed medical assessment of the current health status for the whole population, and train health care workers in use of medicines and implementation of protocols.

7) Support the establishment of a comprehensive system of psycho-social or psychiatric care, capacity-building among local practitioners, and introduction of "new" out-patient or alternative methods such as work therapy.

8) Support small-scale enterprise and agricultural production activities that directly improve the economic condition of those most affected by the conflict.

Findings

Vulnerable Groups

As in the rest of the region, economic conditions within N-K are difficult, and much of the population is vulnerable from an economic and social perspective. For purposes of this evaluation, however, those most directly affected by the conflict were the primary focus. In general, this group is the population of villages damaged during the period of armed conflict, any displaced persons who are within N-K but have yet to return to their pre-war residences, and possibly large families whose primary breadwinner has been killed in the hostilities.

The ICRC identified 43 villages as the most severely affected by the conflict when it began relief operations in N-K. The total population of these villages was approximately 16,600. As of now, the ICRC has decided to phase out relief assistance to 14 of these villages, to restrict and target relief to the most vulnerable 15% of the population within 17 “phase down” villages, and to continue general relief distribution

to 12 “worst off” villages. Assuming an average population of 300 persons per village, adding 15% of the population in the “phase down” villages to the total populations of the 12 “worst off” villages yields a total vulnerable group of about 4,400 persons. Using a total regional population of 130,000, this is slightly more than 3% of the total population.

The two largest “green” areas (inhabited by predominantly ethnic Azeri populations prior to the conflict) in N-K, Shushi/Shushay and Umuglu, may contain an additional but unknown number of vulnerable conflict victims. Umuglu is not a problem area, according to N-K authorities, who note that it was essentially undamaged during the war, and lies in an agriculturally rich area. There seems to be little agreement among various observers about either the number of people living in Shushi/Shushay, their conditions, or any critical humanitarian needs that might exist there. The authorities made a wheat flour distribution there in December 1997, but when repeatedly pressed for details on any critical needs, the "Minister of Social Welfare" made only general references to employment problems, the lack of access to garden plots, and difficulties with the water supply. It is thus not possible for the team to make any quantitative or qualitative evaluation of humanitarian aid needs in Shushi/Shushay, although the N-K authorities’ refusal to place any emphasis on such needs is suggestive.

A group of conflict victims which might be considered more vulnerable is that of large families whose primary breadwinner was killed during the hostilities (or during the border skirmishes that reportedly continue). There are no precise figures for this group. However, there is reason to believe that this group has been and continues to be the recipient of focused aid from the local administration and diaspora groups, which may in effect reduce their actual vulnerability. For example, the Hadrut region has established an in-kind assistance arrangement benefiting families who have lost their breadwinners. The central authority reportedly pays a small pension to children of those killed in the conflict until they reach 18 years of age. In addition, a significant number of private and diaspora organizations whose assistance to Nagorno-Karabakh is listed in USAID/Caucasus documents are described as focusing on aid to families whose members were killed in the conflict.

While social vulnerability is not the focus of this evaluation, the small size of the N-K population allows more detailed comment on the subject. The "Minister of Social Welfare" noted that there are approximately 700 elderly pensioners without family in N-K or elsewhere. Of these, 25 will be accommodated in a purpose-built residential facility operated by the "Ministry". Another facility to house 100 elderly is planned. The " Minister" stated that untargeted external humanitarian assistance is allocated to single elderly as a priority. Thus the primary social vulnerability issue confronting the N-K authorities seems to be approximately 575 elderly pensioners without family ---- a comparatively limited burden by regional standards, and even in terms of the region’s small population.

Public Health

N-K statistics reflect levels of overall immunization coverage ranging from 96%-98%. "MOH" immunization strategy was designed to follow WHO/UNICEF guidelines which are reported to have been adopted as early as 1993. The "MOH" conducts 2 vaccine campaigns a year. Immunization related activities appear on the surface to be well organized and functioning. An estimated 3% of children have not received vaccinations. However, in direct contradiction to "MOH" statistics, an independent study estimated measles coverage at 37.8%. Hidden problems of vaccine supply, cold chain or drug effectiveness are reflected in disease incidence. For example, there were 191 cases of measles and 2 cases of polio during 1997 as well as a diphtheria outbreak in 1996.

Spread of TB is a quiet time bomb in the region due to 1) improper treatment of the disease 2) high drop-out from treatment programs before being cured and 3) failure to implement WHO protocols. All three have contributed to increasing drug resistance. However, in Armenia, Azerbaijan and N-K, international organizations are actively involved in encouraging adoption of WHO treatment protocols.

The homebound war-wounded are a small but forgotten population estimated between 50 to several hundred individuals. They present a costly drain on family finances and an emotionally difficult burden. The N-K "MOH" might be prepared to minimally cope with their in/out patient care, but lacks capacity to provide appropriate lifecare to permanently handicapped.

It has been reported that as much as 80% of drug supply and equipment are stored in the N-K authority controlled central Humanitarian Warehouse. However, medicines are short throughout N-K and available medications are expensive. Three possible explanations for the warehouse bottleneck are[2]: 1) the stock is kept centralized in case of war, 2) warehouse managers justify their positions and employment by hoarding the stockpile or 3) there is no political willingness to distribute the drugs.

Diseases causing morbidity and mortality, (with the exception of the high prevalence of TB,) [3] appear to reflect the local diet, lifestyle and climate, and are not significantly different from those found in the region. In adults these include hypertension, heart disease, cancers, diabetes, etc. In children and adults respiratory infections, colds, and skin diseases are most commonly cited by the medical community.

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[2] K. Lattu (1/20/98) conversation with Miguel De Clerk, MSF-Belgium Head of Mission and former member of the N-K MSF Exploratory Mission.

[3] TB is already being addressed through the renovated Karabakh TB hospital.

Medical personnel report all diseases are exacerbated by the stress of war. Drug abuse exists, but at an unknown rate. Parents frequently mention that they and their children spent part of the war fleeing, or living hidden in crowded basements for a year or more. There is no comprehensive system of referral, knowledge of updated methods or adequate care available for psycho-social or psychiatric problems. The current psychiatric hospital is a half heated building with a capacity of in-patient beds that allows institutionalization of severe cases. Both in-patient and out-patient services follow unclear diagnostics or treatment regimes. Counseling as it is known in the west is non-existent.

Food Security

The team found no evidence of acute malnutrition, nor any superficial indications of chronic malnutrition or other serious and systematic nutritional problems. Chronic malnutrition, evidenced by stunting in children, has been documented in both Armenia and the rest of Azerbaijan, and it is likely that such problems also affect at least a portion of the population of N-K. Lack of diversity in the diet is very likely among the urban less well-off, with consequent micronutrient deficiencies. But availability and access to food do not appear to be serious problems for a significant part of the population. Every individual, official or private, local or foreign, with whom the team came in contact was queried about food security issues. No one provided specific negative information or indicated any strong concerns regarding food security.

Local conditions support the conclusion that food is not a major problem. N-K, previously a prosperous agricultural area, may still be a cereals-surplus region. According to N-K authorities, the region exported 15,000 metric tons of wheat to Armenia in 1997, and a lesser amount the year before. This cereals surplus comes despite the fact that large amounts of the best grain-growing land in the north are not cultivated due to their location in zones of military activity. The availability of cereals, combined with the ready access to gardens and often livestock by those outside the regional capital, would indicate no food security problems for the bulk of the population, who live in the rural areas.

The potentially more vulnerable urban population (single elderly, unemployed) would benefit from the general availability of food in the region, and presumably from family or other informal networks linking rural and urban populations. In the Hadrut region, the local “safety net” arranged by de-facto regional administration involves provision of wheat and other agricultural products by relatively prosperous families (including some involved in commerce and not agriculture) to families of men killed in the conflict. This relatively formal system supplements whatever informal networks exist, although it is not known if the Hadrut system has any counterparts elsewhere in N-K.

Shelter

The authorities informed us that they had successfully rehabilitated approximately 8,000 single-family dwellings, repairing one or more rooms to permit families to return to their homes. In addition a further 1,500 apartment units have been rehabilitated sufficiently to allow families to return and occupy the space. It appears that an additional 5,000 dwellings and/or apartments remain to be rehabilitated, (or approximately 33% of the damaged housing stock.) Some sources suggest that as many as 3,000 of the 5,000 refugee families who have (or had) been living in Armenia have already returned to N-K, and are living with relatives, or have doubled up with other families in temporary quarters. The potential need for a shelter program for N-K is manifest. It can help generate employment through direct reconstruction, allow people to return to their homes, improve their health, and permit families to resume normal lives, and undertake normal commercial and economic activities.

Water and Sanitation

The team visited three urban centers and three relatively representative villages in N-K. The towns included Stepanakert (or Khankandi) the provisional capital city, plus Mardakert/Agdara, a region capital in the north, and Hadrut, a region capital in the south. In Mardakert/Khankandi the team visited two villages, Gulatagh and Janatagh. In the southern part of N-K, the team visited the village of Kochbeck. (Short profiles of each of these regions and villages are given in an Annex.) From what the team was able to determine from interviews and conversations in urban centers and from these short visits, the provision and adequacy of water (and/or sanitation) did not seem to be an urgent priority. The authorities were explicit in indicating that they did NOT seek assistance in repairing the larger urban potable water systems. The villages have traditional watering points, many of which come from artesian sources. These sources generally seemed to be relatively potable. When we queried staff from international donor agencies working in NK about their experience with the local water, they advised us that they routinely drank the water, and did not become sick. As the area moves towards systematic reconstruction, there could be economic advantages in terms of the use of people's time if community water and distribution systems are repaired and put back into service, but it does not seem to be an immediate priority. For the time being, sanitation issues do not seem to be a significant public health problem.

Other issues

The apparent strength, focus, and engagement of the de-facto local administration in N-K was striking. In each location the team visited, the local authorities demonstrated a detailed familiarity with the specific problems of the community. It appeared that urgent local needs were factored into the authorities' priorities and actions. The sense of a close connection to specific community conditions was also present at

Stepanakert/Khankandi. The team found this to be a key factor in helping the community cope, with apparent success, with the challenges of the situation.

Land mines and unexploded ordnance continue to pose a hazard to humans, livestock, and farm equipment in N- K. No reliable figures seem available, but the consensus among local authorities and the ICRC indicates that just a few cases of mines/ordnance-related injuries occur every month. Fatalities occur infrequently, and local authorities indicated repeatedly that mines and ordnance are no longer a critical humanitarian problem. The ICRC confirms this view. According to all sources, local populations are generally familiar with the most dangerous areas of their villages and regions, and avoid them. In addition, the internal mine-clearance capacity of local military authorities, a result of training by the British NGO Halo Trust, is now used to clear high-priority land. According to local authorities, for a cost of $200/hectare, this authority will clear agricultural land for local farms.

According to local N-K authorities, the mine/ordnance problem is under control, but it still exists. In addition to any human injuries or deaths still caused in such incidents, the economic toll of the problem is important. Livestock are regularly lost to mines, and the destruction of the region's dwindling stock of farm equipment such as tractors and combines is weakening the agricultural sector.

AZERBAIJAN

Conclusions

There is no acute humanitarian crisis in Azerbaijan among victims of the Nagorno-Karabakh conflict. Conflict victims are affected by the same impoverishment suffered by the majority of the general population, although in most cases they endure inferior shelter conditions. Azeris residing in the districts along the northern border with Armenia continue to be directly affected by the conflict, as cross-border hostilities have reportedly compounded the challenges posed by inherently limited economic opportunities and lack of central government assistance. Some 600,000 internally displaced persons (IDPs), in varying conditions and with varying capacities to provide for themselves, remain a serious economic and political burden on a country struggling with post-Soviet economic deterioration. Little is known about the status of 200,000 refugees, who are also victims of the conflict over N-K.

1) With the deteriorating economic conditions across rural Azerbaijan, the IDPs and refugees no longer constitute a uniquely vulnerable population. It's important to look at the overall situation for the whole population, and view the IDP and refugees in context. As the economy contracts, the resident or Azeri 'middle class' is being squeezed or eliminated, and the whole society is becoming more sharply stratified. While the IDPs represent 8% of the national population, the incomes and quality of life for an additional 20% of the population is also deteriorating significantly.

2) Agricultural production is declining dramatically, (some say collapsing), and land reform actions may lead to increased pressures on the IDPs, as well as on local populations. Some estimates of overall unemployment across Azerbaijan run as high as 80%. Whatever the figure might be for the local population, it appears that unemployment for the IDP population is probably higher.

3) Of the estimated 600,000 IDPs, perhaps the bottom 25% or 150,000 people are characterized as particularly vulnerable, based on their incomes and shelter conditions.. Other indications suggest that as many as 90,000 families (or more than 300,000 people) could be living in sub-standard conditions.

4) Some degree of friction is developing between the IDPs and the local population, because the IDPs have a minimal social safety net in terms of food supplements and access to medicines, unlike the local population.

5) An adversarial relationship exists between the government and the international

assistance community, and some knowledgeable agencies believe this condition is becoming more marked.

Recommendations

A humanitarian assistance program for Azerbaijan should:

1) Review conditions in the northern border districts to determine whether additional humanitarian assistance is called for to the most vulnerable in those areas.

2) Give priority to improving shelter conditions for the more vulnerable of the IDPs.

3) Support income-generating activities that *inter alia*, enable families to pay for healthcare not provided by NGOs or international donor agencies..

4) Support wider dissemination of health educational and medical resource materials.[4]

5) Increase support from the international community to implement WHO protocols for communicable diseases such as TB, malaria, etc.

6 Improve the international community's capacity to monitor, evaluate, and plan assistance for the IDP and refugee populations.

Findings

Vulnerable Groups

Economic crisis since the collapse of the Soviet Union has driven the vast majority of Azeris into difficult circumstances. Apart from limited labor market impact in the Baku area, the ongoing development of Azerbaijan's hydrocarbon energy resources has not much affected the economic condition of the country's population. Because changes since the Soviet collapse have propelled many Azeris into various levels of economic insecurity or impoverishment, many social categories (single elderly, those in social institutions, large families without fathers, and others) could be said to be vulnerable. This evaluation, however, is focused on the victims of the Nagorno-Karabakh conflict,

[4] Examples include MSF's Standard medical protocols in Russian; IRC's Azeri translation of "Where There is No Doctor," and other publications on Mother Child Health including breast feeding, immunization, and safe motherhood.

and all figures on vulnerable populations are limited to this group. Other than to note the more widespread problem, no effort is made here to make specific comparisons between the situation of conflict victims and the socially vulnerable population.

Azerbaijan has an internally displaced person (IDP) population somewhere between 550,000 and 600,000. Forty percent of the IDPs or 200,000 people are living in urban settings in Baku and Sumgait. The balance, or an additional 400,000 IDPs, is scattered across the interior of Azerbaijan. Approximately 10% or perhaps 60,000 live in camps. Others live in public buildings, box-cars, squatter settlements, or in a few cases, in caves. Among the IDPs, perhaps (2 %) have been able to return to their homes.

In addition to the IDPs, there are an additional 200,000 refugees,[5] who are mostly in the vicinity of Baku. Conventional wisdom suggests that they are assimilating into the local population without undue strains on either side. (The team did not have the time to confirm or refute this conventional judgement.)

In Azerbaijan, the vulnerable population of N-K conflict victims must be considered primarily as a subset of the IDPs. Of a total estimated IDP population of 600,000 in Azerbaijan, UNHCR estimates that 150,000 are the most vulnerable, based on surveys of IDP economic conditions. Factors making for greater relative vulnerability of IDPs are readily known, and include poor shelter, lack of access to either employment opportunities or garden plots, etc. However, precise figures for the percentage of IDPs affected by these various factors are not available. The total displaced population within Azerbaijan represents +/- 8% of the total population. The putatively more vulnerable 150,000 within that larger group are 2% of the total population.

In the time available, it was not possible for the team to arrive at a reasonable estimate of the IDP population living in unacceptably bad shelter. Given the scale of the problem, however, and the fact that large public building rehabilitation assistance has been under way for just over a year, it seems reasonable to use the 150,000 most vulnerable IDP figure as a minimum or floor for estimates of vulnerable conflict victims.

Because shelter is the most readily verifiable factor directly affecting the health and welfare of refugees, the most vulnerable part of the population among conflict victims in Azerbaijan are IDPs living in unhealthy substandard shelters.

In addition to this group, an unknown number of Azeris residing in the northeast border districts with Armenia, which continue to be affected by the conflict, could be

[5] In addition to the 200,000 refugees who are victims of the N-K conflict, Azerbaijan is also host to an additional 40 - 50,000 Muskadi Turks, who are not victims of the conflict.

considered part of the vulnerable population.

Public Health

For the majority of IDPs and refugees, both medical consultations and minimal treatment are provided for or subsidized by the international community. The MOH assesses additional charges during hospitalization or special treatment, regardless of socially vulnerable status within the national healthcare system. This policy inadvertently targets indigents, who are frequently IDPs or refugees. Women, as primary caretakers of children and high users of hospital services, are especially vulnerable to a system requiring payment for services. As a result, they sometimes don't seek care or do so outside the health system as is evidenced by the more than 22% of women who give birth at home and an estimated 70% with untreated pelvic inflammatory diseases.[6] Overall, IDPs have better access to health education, reproductive health, and charge-free services than the average or low-income Azeri.

Spread of TB is a quiet time bomb in the region due to 1) improper treatment of the disease 2) high drop-out from treatment programs before being cured and 3) failure to implement WHO protocols . All three have contributed to increasing drug resistance. However, despite their being a draft national TB program within the Ministry of Health, it does not appear to respond to adoption of WHO treatment protocols. Some conclude that the draft plan has hit a political roadblock and it may be a dead document.

Food Security

Food security does not appear to be an acute or widespread problem among conflict victims residing in Azerbaijan. Several agencies, including the World Food Program (WFP), have been providing supplementary rations to IDPs for several years. The caseload of IDPs receiving rations has declined gradually, as agencies have scrubbed their lists for IDPs collecting food aid from more than one source. In all, WFP estimates that 533,000 IDPs are on food aid distribution lists in Azerbaijan. All agencies providing food assistance, like those providing other forms of humanitarian aid to IDPs, coordinate their activities on a geographic basis within Azerbaijan. They also for the most part have standardized their rations.

[6] Statistics from one NGO's reproductive health program, unpublished 1997 annual report.

The provision of a supplementary ration by food agencies is a recognition that most IDPs have some economic resources and in some cases access to agricultural produce or garden plots where they can grow some of their own food. Several assistance agencies have included greenhouse and garden plot activities in their IDP programs for several years in an attempt to raise the quality of the IDPs' diets.

In keeping with the Government of Azerbaijan's policies regarding IDP assistance, no food aid is provided in the Baku/Sumgait region. While the Government's policy on this region has been modified to some extent in the sector of public building rehabilitation for IDPs, apart from an earlier and short-lived food distribution program by a now departed European NGO, there has been no food aid program in the Baku/Sumgait region. The approximately 200,000 IDPs resident in the Baku/Sumgait area are presumed to have greater access to economic opportunities with which to provide for their own food needs. In visits to several IDP sites in the region, questions about food access and availability did not elicit any expressions or observations indicating a food security problem.

The ICRC distributes food aid to 9,000 families in the northern border districts with Armenia. The ICRC hopes to increase its understanding of the humanitarian situation for residents in that region as it improves its access to the area; Azeri military checkpoints have not been completely cooperative in allowing routine access for the ICRC to the border areas.

It should be noted that chronic malnutrition (prolonged insufficiency of dietary intake), as evidenced by stunting among children, has been observed both within the IDP and resident population in Azerbaijan for several years by nutritional surveillance activities. This phenomenon can have complex causes, but among these are almost certainly the economic effects of dislocation and low incomes and the physiological effects of poor living conditions and diets. As its origins can be complex, chronic malnutrition is not a problem on which limited, short-term humanitarian interventions are likely to have much impact.

Shelter

The provision for shelter in Azerbaijan among the IDPs appears to exist along a continuum extending from (1) caves, (2) tents and lean-tos, (3) railway cars, (4) squatter settlements, (5) camps, (6) Rehabilitated Public Buildings, and (7) private dwellings. The quality of the various dwelling types ranges from the seriously inadequate to the relatively comfortable. While virtually the entire IDP population appears to have some form of shelter,[7] there appears to be no common definition of

[7] During the trip the team heard no anecdotal evidence of IDPs who were literally

what should constitute adequate housing, and no overall system for monitoring or evaluating the equity of shelter improvement programs. Within each separate category of shelter, wide-ranging variations are possible. In some cases it appears that women-headed families have systematically received access to poorer quality shelter. While no absolute numbers are available, on balance it appears that thousands of families are living in shelters, which are seriously inadequate, given the climatic conditions with which the IDP populations must cope. The inadequacy of shelter has a direct impact on family's health, involving significantly increased incidences of upper respiratory diseases, scabies, and transmission of communicable diseases.

Water and Sanitation

Water and sanitation are issues that need to be surveyed and monitored systematically in Azerbaijan. Generally, problems with water and sanitation correlate with the quality of shelter. Those IDPs living in the worst shelters, for example, typically also have the worst access to water and sanitation provisions. There clearly are problems in some settlements with the provision of water and its quality, and some problems with sanitation. In the event of unseasonable flooding, for example, there could be outbreaks of water borne diseases. However, in broad terms, water and sanitation issues should be viewed as a sub-set of the problem of shelter. The international community should establish overall norms for the provision of adequate shelter, water and sanitation. Once such norms are defined, there should be appropriate efforts to see that minimally adequate housing with suitable water and sanitation provisions are supplied to all of the IDP communities across Azerbaijan, including hard-to-reach populations living in railway cars, squatter settlements, etc.

Other issues

A.) Land mines and unexploded ordnance have not yet become a major humanitarian problem in Azerbaijan. It is anticipated that the problems posed by mines will mount as and when IDPs return to home areas that were the scene of armed conflict. The ICRC has had a mine awareness education activity under way in Azerbaijan for one year, and would step up its efforts in the event of any large-scale return of IDPs.

B.) Monitoring, surveillance and planning appear to be areas where the international community could use some additional resources. At the present time the international assistance community is somewhat fragmented. While individual donors and specific NGOs do good work in their particular part of the country, no macro-level capacity appears to exist to carry out comprehensive monitoring and evaluation of the overall

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homeless.

IDP/refugee situation. This possible deficiency should be analyzed. If confirmed, an enhanced survey and monitoring capacity should be created, probably under United Nations auspices.

Potential Program Opportunities

Within the broad framework of the provision of humanitarian assistance for victims of the N-K conflict, the United States Government seems to have five broad areas where it might target expanded assistance programs. These include:

1. Shelter rehabilitation

2. Public health assistance

3. Income generation activities

4. Community development activities

5. Monitoring, Evaluation, Surveillance and Planning Capacity

The specific needs in Nagorno-Karabakh differ from the needs in Azerbaijan, but the differences typically are ones of magnitude, rather than the kind of assistance required. The total number of IDPs and refugees in Azerbaijan, for example, is nearly 8 times the total population of Nagorno-Karabakh. The need for a monitoring and evaluation capacity to track the status of IDP populations in Azerbaijan is correspondingly greater than for Nagorno-Karabakh. Similarly, the displaced communities in Azerbaijan have negligible social infrastructure in place to help knit them back together, while the communities in N-K seem to have strong social cohesion. Thus the absolute need for community development work in Azerbaijan seems substantially greater than the absolute need for such work in N- K. In terms of specific sectoral activities in public health, income generation, and shelter, the needs are largely a function of the populations which are on the ground in a given area. All other things being equal, a larger population in need would generally call for a greater level of effort.

Most of these possible programming initiatives -- particularly the need for shelter and appropriate public health interventions -- have been fully described in earlier sections of this paper. A few things remain to be said about the other possible interventions. These are briefly discussed below.

Income generating activities

Income generating activities are a critical need for all the victims of the N-K conflict. The need for employment is a constant which cuts across the entire Caucasus.

This requirement for employment generating activities seems to be a key issue in all three areas. However, there may be some differences of degree between or among the three areas. N-K has a relatively strong civil administration in place. Many of its formerly displaced persons have returned to their homes, and are beginning the process of reconstructing their lives. They need assistance, but important social, economic, political, and community institutions are intact, or are being reconstructed. These people are grounded; have access to some land; and are resuming agricultural activities at a level somewhat above subsistence. The primary need now after some assistance with shelter is for the international community to help promote income generating activities.

In Azerbaijan, on the other hand, where there is a much larger IDP population, people have not returned to their communities, and the incidence of apathy and alienation appear much greater. Some NGOs have commenced limited income generating activities among these populations. Much more work needs to be done in this area.

Community Development Activities

Community development activities are an important corollary priority. In N-K, villages are coming back together utilizing their own resources, with additional support from the Diaspora, and the Government of Armenia. In Azerbaijan, on the other hand, the communities typically lack national government support, but they also lack established socio-cultural networks to help them re-integrate their communities. The communities the team saw were essentially holding camps for displaced people, rather than villages which are coming together with the normal amenities of village life. There were virtually no tea shops, for example, and no villages councils. There are few building maintenance committees. There appear to be a few women's groups.[8] Schools are used only as schools, and don't double as community centers, where people can come together in the evenings for social functions, or to work out strategies to help improve their communities. Many of the NGOs working in Azerbaijan have some level of experience with relevant community development methodologies. It seems important to put additional program resources into developing communities, in order to utilize the energies of the IDPs. This seems particularly among the IDP communities in Azerbaijan.

Monitoring and Evaluation Capacity

In N-K the population is small and the number of international donor agencies is limited. Coordination does not currently seem to be a serious problem, but with expanded levels of assistance, this area might need some limited assistance in the future. Perhaps a small planning cell should be established, to insure optimum utilization of U.S.

[8] One member of the team found indications of a few NGO-fostered women's groups that originally met for community health activities, but now seem to be somewhat cohesive cohorts that offer peer support to members.

Government and international donor resources.

In Azerbaijan, on the other hand, the donor assistance community is somewhat balkanzied and fragmented. Individual donors and specific NGOs are doing good work in their particular part of the country, (although there are different standards and levels of assistance being provided.) However, currently no macro-level capacity appears to exist to carry out comprehensive monitoring and evaluation of the overall IDP/refugee situation. One simple example of this is the lack of meaningful data on the actual status of the refugees, (in contract to data about the IDPs). The conventional wisdom is that approximately 200,000 refugees have largely found new lives for themselves in and around Baku. This particular assumption should be probed and tested through appropriate survey techniques.

To address this apparent deficiency, a suitable survey and monitoring capacity should be created, probably building upon the work which the various United Nations agencies have already done, including UNHCR, UNDP, and UNDHA. Some additional capacity needs to be generated, involving enhanced use of computer based planning technologies, (such as Geographic Information Systems), together with relevant survey data collection and planning techniques. Save the Children, with support from USAID, has made an important step in creating a planning framework to hold the results of such survey data, by generating a software program called Azer-Web. The data which are beginning to flow into this software program represents a good place to begin working on a larger and more comprehensive planning and coordination system for Azerbaijan.

Annex A
Field notes, Visit to Nagorno Karabakh

[Dennis Culkin and David Garner visited the provincial regions of Martakert/Agdara in the North of N - K, and Hadrut in the South on the 23rd and 24th of January. They met with provincial officials, briefly toured parts of both regions, and visited three somewhat representative villages outside the provincial capitals. Field notes for these visits are given below. The team made the decision to visit particular villages because of propinquity to the provincial capitals, due to limited available time. These villages were not suggested by the authorities, and appear to be at least somewhat representative of the regions visited.]

1. Region of Martakert/Agdara

Principal informant: Abraham Slavoko, chief of Regional Administration, or Governor, who has worked in the area since 1988, and has been governor since 1993. Trained as a cybernetics specialist. The prewar population of the rayon was 46,000. Now the population is about 23,000. There are 46 villages in the area, of which 7 remain under Azeri control. The front is 5 km away, and there is still some shooting. The firing is mostly snipping across the border. In 1992, the rayon was 90% occupied by Azeri forces. It took almost two years for the N-K forces to recapture the 33 occupied villages.

The 7 villages still under Azeri control possess 20,000 ha of land, or approximately 70% of the arable land of the region. The governor observed that if they were to retrieve those 7 villages, they would secure a major portion of the region's [the region's, or all of N-K's?] arable land. In addition, the principal irrigation channel passes through the occupied territories, so much of the land which normally would be irrigated is unusable. Before the war, the region produced approximately 90,000 MTs of grapes each year. Now the vineyards have been destroyed by fire, and production is negligible. Perhaps 95% of the vineyards are gone. In addition to those vineyards destroyed by fire, others have been mined. And still others which could be used are located along the front, so workers are at risk from snipers, and the fields are left dormant.

After May, 1994, people started returning to Martakert/Agdara. At the time, there was hardly one house in the whole area left standing. Roads had been destroyed. People lived in barns, and whatever shelters they could find. Initially relief assistance came from ICRC, in the form of food. The governor emphasized that there have been good relations between the authorities in Martakert/Agdara and ICRC. After some time the authorities determined that people can't live off of humanitarian assistance forever, so they asked ICRC to purchase things locally to make them available to local vulnerable people. The ICRC appears to have readily complied with this request, as part of an effort to help return the area to agricultural self-sufficiency.

In the town of Martakert,/Agdara there are between 5,000 and 6,000 families, of whom about 2,100 to 2,200 currently don't have housing. These families are staying with relatives, or are given temporary shelters in public buildings, or in a few cases living in barns. The water system for the town comes via the front lines, so this has caused some problems. In the summer water runs out, so it is necessary to supplement water supplies by using tankers.

Martakert (Agdara) region possesses 70% of the forests of the region. Its higher elevations extend up to 3,200 meters. The Governor characterized his region as 'the Switzerland of N- K.' He also said there was a gold mine in the region, and indicated there might be some coal, (which was not mined before the war.)

A few years ago the collective farms of the regions were converted into collectively owned 'joint stock' farms. Now the authorities are initiating a more comprehensive land reform program. In five villages, land has already been distributed to about 500 people. Currently farmers are leasing land, but this year the authorities will formally distribute it to small farmers. The authorities will also keep some land under its control, [apparently this is either commons lands like forests, or it is for subsequent distribution.] The governor appeared to say that of the 30 collective farms in the region, about 80% will be privatized.

He said that before the war, 90% of the population of the region had been employed in agriculture, while the remaining 8 - 10% included doctors, teachers, and government employees. At another time he has said that the region included 15 - 20,000 farmers, [seemingly meaning people who worked in one way or another on the various collective farms before the war.] The region also had had a wood processing plant, and two small construction companies.

A dam producing 50 megawatts is located about 12 km north of Martakert/Agdara, which provides much of the electric power for the area. It was built in 1976. It appears that the current storage capacity of the dam is sufficient to generate power for 6 to 7 months per year. The turbines at the dam are said to still be in good condition. There is good potential for micro-hydropower in the region. There are also plans to divert a river from the northern part of the region and put additional water into the reservoir. This would extend the period when the dam provides power by a month or two each year, and increase power generation by about 5%. Because there is a substantial difference in elevation, it would easy to put two or three additional dams for power generation along the newly diverted river. While the two provincial capitals of Martakert and Hadrut had some electricity, the governor said that some villages in the region had been without electricity for four years.

The governor stressed the importance of a hard surfaced internal road network within the boundaries of N-K, so that it would not be necessary to travel into the occupied territories

(areas outside the pre-war borders of the autonomous N-K oblast) to have access to paved roads. He made similar observations about the importance of internal telecommunications systems, and stressed the region's needs for agro-processing and agricultural equipment.

2. Village of Gulatagh, (approximately 10 km outside of Martakert)

Our principal interlocutor was the Mayor, Valery Danielian, who has been in office since February, 1994. The town before the conflict began had consisted of 169 families, with a total of 484 people. Now there were 83 families with a total of 220 people living in the village. In effect, the village is now 50% of its pre-war size, in terms of population. At the present time, 66 families live in 66 houses. An additional 17 families share this housing, for a total of 83 families in the village. For a while, some of these families had lived in the village school, although this is no longer the case. In terms of shelter, therefore, the village is nominally about 40% reconstructed relative to its pre-war level. Most of the families living in the village returned in 1994 or 1995. The remaining population will return when shelter becomes available. Our meeting was held in the mayor's office, which was located in the school. The school also contained a 'medical point,' which seemed to be a small dispensary for emergency medical care. It was locked while we were there. The village was also said to have a small library.

Before the war, the village had been part of a collective farm with a total area of 2,150 ha, including 800 ha of vineyards. The farm had specialized in wine making and cattle. The winery produced 7,000 Mt of wine / year. Of the farm's arable land, now only 350 ha is available for cultivation, and the village is cultivating only 40 to 50 ha, or less than 3% of the pre-war total. The mayor said that 27 of the families have household garden plots. [It was not clear if these plots were included within the total 40 or 50 ha.] The current crops are wheat, corn, and vegetables, some of which was sold in Martakert, but most of which was consumed locally. Tomatoes in season appear to be a popular crop for household gardens, and for potential sale in Martakert.

The labor force is limited, largely because of the exigencies of the continued war mobilization effort. The village population includes 86 pensioners or old persons, and perhaps 60 adults (both men and women) of working age. In a slightly different context, the mayor estimated the effective labor force at about 45 or 46 persons, including 30 farmers, and 10 'nurses.' Most young men are still in the army. The community also consists of 50 children, of whom 45 attend a local school. Fourteen teachers are assigned to the school, of whom 12 are local, and two are volunteers.

Bombs and mines continue to be a problem. In November one villager was killed by mines. Halo Trust has mapped mine fields and plans to come back in the spring to clean some additional area. One number given with no additional context was that 9,540 ha of agricultural land had been mined. [It was not clear if this was a total for the region, or

something else.]

In terms of living conditions, no one was malnourished in the village, but quality of food is limited. The villagers had been receiving periodic deliveries of supplemental food rations from ICRC. These consist of 10 kgs. of wheat flour, and some other provisions every few months. One delivery had been in July. The most recent delivery had been two months ago in November. Before the war, the village had a water distribution system, but this has been destroyed. They seem to have no functioning farm machinery, and now have to borrow trucks, tractors, and combines to carry out routine agricultural activities. The total production of the farm before the war was said to have been 35,000 MT of wheat. Now, said the mayor, the whole region is barely capable of producing what used to be produced by one small farm.

3. Village of Janatagh (15 kilometers from Martakert?)

Our principal interlocutor was Vladimir Martirosian, the mayor of Janatagh, who was a refugee from Baku in 1990. He was elected Chairman of the council in 1992, and became mayor in 1994. The town apparently had consisted of about 270 local families, and now seems to consist of about 124 familles, with a current effective population of about 350 people, (or slightly less than 50% of its prewar population on a per family basis.) In addition to this, the mayor seemed to indicate that an additional 400 refugee families from the Baku region had been reassigned to live in or around this village, so the net effective population if these families were to come would be somewhere around 1,800. Because many of the 124 families currently were doubling up, the mayor felt that the village needed to rehabilitate another 10 to 15 houses just to take care of its current population. In addition to this, he estimated that perhaps 8 additional families would return to Janatagh in 1998, requiring further housing rehabilitation work. [It was not clear where or when the 400 refugee families might arrive; where they were currently housed; or whether any of the 124 families aside from the mayor himself already were included among the current population.]

Before the war the village, (collective farm) had farmed approximately 1600 ha of arable land, including 800 ha of wheat, and 800 ha of vineyards along the border. In 1998, the village was farming only 70 ha of land, (or less than 5% of the pre-war total.) In addition to this, neighbors from another nearby village were leasing an additional 10 ha. which they had planted in wheat. The crops today are wheat, corn, potatoes, and water- melons. Now, 95% of the land being cultivated is dryland.

The labor force of the community consists of 11 teachers, (teaching 74 students from 1st to 10th grades), plus 2 nurses, 5 people who worked in the Mayor's offices, 15 laborers and another 12 pensioners who could do some farm work. The mayor estimated an effective labor force for the village of about 35 persons. In addition to this there seemed

to be a substantial number of pensioners, most of who were old and disabled and unable to work.

Agricultural equipment is a serious problem for the community. They had had two tractors, both of which had been destroyed by mines a couple of months earlier. They had one truck, but it was broken. Before the war, by contrast, they had had 28 tractors, and 1,000 head of cattle, 500 sheep, and 800 pigs. These were all destroyed, or stolen when the village had been occupied. Today, however, only that handful of villages that had not been occupied still have their agricultural equipment intact. This suggests that these seven villages are supplying the bulk of the machinery necessary for the region's agricultural activities and that the rayon might have approximately 15% of its pre-war ag machinery capacity. However, as the mayor pointed out, this remaining machinery is increasingly old and obsolete.

The mayor emphasized the importance of agricultural equipment as part of the local economy. In 1996/97, he said, two tractors had been destroyed, with one driver being killed and the other being hurt. Forty cows had been killed by mines. So while perhaps 80% of the population of the area was generally in adequate condition, the mayor felt that without adequate agricultural machinery, things were becoming somewhat more problematic.

The mayor also said that the mayors and local village councils were going to be up for election in April, 1998. He had been appointed, he explained, but they were shifting over to direct election of local officials. If N- K proceeds with this plan, then these newly elected village councils might become interesting vehicles for channeling reconstruction assistance. The new village councils will have responsibilities for overseeing such things as local medical services, education, local law and order issues, and some matters relating to farming. The mayor will oversee the work of each village council, and the council will have responsibility for each collective farm.

4. Hadrut Region

Our principal interlocutor for our visit to the Southern part of NK was Serge Sergisian, "Chief of the Regional Administration of Hadrut Region", or Governor. Mr Sergisian was trained as an economist, with an emphasis on statistics. He explained that Hadrut was not nearly as wealthy as Martakert before the war. It had had about 6,000 ha of wheat before the war, and again grows this amount of wheat. However it had had 3,000 ha of vineyards before the war, and of this only about 100 ha remain. The population in 1988 had been about 14,500, including 2,000 Azeris. Now the population was about 11,000 people.

Before the war the Region had consisted of 42 villages. During the war, 14 of these villages were captured, and 4 seem to be located along the border or front area, and so

perhaps are in no man's land. It was not clear exactly how many of these 42 villages are under N-K control today. The town of Hadrut had had a prewar population of 2,400. During the war this swelled to 4,000 people, but now it was back down to 2,400.

In terms of housing, before the war the rayon had about 4,500 dwelling units, of which 1,500 were destroyed, leaving about 3,000 today. The authorities are reconstructing between 25 to 30 houses a year; private resources are reconstructing an additional 20 houses for a total of about 50 per year. At this rate reconstruction will take approximately 30 years.

Before the war the region had had no industry except for three wineries. Of these two have been destroyed, and the third is not operating. There were 330 kms. of roads, of which 3 had been paved. All these roads were in use now, but 15 villages become inaccessible during the winter months, because of a lack of maintenance on the roads. From what we could see, there had been little or no graveling of these mud roads. The region receives its electricity from Stepanakert. The power went out in the governor's office as we were talking, and he said that five villages currently are not connected to this grid. For water, most villages used springs, although 10 villages had had piped water systems. Heating was primarily by wood.

In terms of agricultural machinery, the region had had 250 tractors, of which 60 remained; 26 combines, all of which remained; and 400 trucks, of which 40 now remained. (Comparing aggregate totals for all prewar ag machinery suggests that less than 20% of the prewar capital stock remains.)

In terms of students, the region had had 2,500 before the war; it has 2,100 now. The birth rate was essentially constant, averaging about 240 per year.

Because the Governor had a good feel for overall economic activities in the region, the team asked him how the war had impacted people's lives in economic terms. He said that for the whole region, wheat production was approaching pre-war levels. He thought that for individuals, per capita income was perhaps 60% of the pre-war situation. However, he felt that total production for the entire rayon was perhaps 20% of the pre-war situation, because the vineyards and wineries were out of production, and cattle production was substantially down. He felt that across N- K, economic production was at about 40% of prewar levels. However he believed that with peace, it would be possible to reach prewar levels within a couple of years.[9] In terms of employment, he thought that about 70% of

[9] This judgement may prove unduly optimistic for the following reasons: 1) much of the income of the rayon seems to have come from grapes and wineries; 2) most of the vineyards have been destroyed, and/or mined; 3) new grapes take 4 - 5 years to come into production; and 4), perhaps most significantly, the Caucasus seem to have lost many of their traditional markets, and the farmers and government officials are not currently

the labor force of the rayon was employed, [suggesting a nominal unemployment level of 30%, which sounds like it may understate the actual levels of unemployment, or under-employment. This number should be probed further during subsequent trips into the area.]

5. Village of Kochbeck. Located 15 minutes from Hadrut.

The team's principal informant was the mayor, Mr Norashan. Notes for this visit are a bit sketchy, as time was running out, but we learned that the village had been occupied by Azeri forces for about 18 months, and during this time the population had moved to Hadrut. During the war, the mayor said that the village was about 50% destroyed. The village seems to have had a pre-war population of about 280 people; now there were 155 people. The village had had 55 households, of which 12 were destroyed, and 6 were damaged, suggesting that about 33% of the direct housing stock was destroyed. Other public buildings and agriculturally related structures presumably were also destroyed through the fighting. Fourteen of the 18 damaged or destroyed houses have been restored to some level so they can be used; four remain to be restored. Four or five of the existing houses have two families living in them.

The village cultivated about 120 ha of wheat before the war, and a similar amount now. They had also tended about 80 ha of vineyards, however, which are mined, and now out of production. Most of the wheat they grow is used for local consumption. The sources of cash income for the villages include some income from pensions, plus a few people who are able to work in Hadrut. Only an estimated 20 people now work on the collective farm attached to the village of Kochbeck.

In terms of health services, the village has a 'medical point,' with a female nurse, who is present in the village. They also use the regular hospital in Hadrut, which is 15 minutes away. The town of Hadrut has a 120 bed hospital. In addition, the region has 4 smaller hospitals with a total of 65 additional hospital beds.

In terms of priorities, the mayor thought that agricultural equipment was the village's highest priority, because they only had one tractor left. To harvest their wheat, they have to rent a combine from another village.

The pre-war Fizuli/Nagorno-Karabakh oblast border happens to cut through the village of Kochbeck, with perhaps 7 or 8 of the 55 houses located across this line. Villagers had restored two of these houses. One resident of the village came up to the team as we were leaving and said that he had not originally come from Kockbeck. He was identified by

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equipped with many of the necessary skills to help them find new international markets for their produce.

other villagers as an immigrant from Armenia. However, this was the only resident in any of the areas visited by the team who appeared to be from Armenia; all the other occupants the team saw in the three villages we visited seemed to be long-term occupants of the area, or in the case of the mayor of Janatagh, were refugees from Baku.

The two governors spoke of the local populations as people who had been living there all their lives. The mayors repeatedly spoke of people 'returning' to their villages. From our visit the team did not receive the impression of any significant new population moving into these villages. These villages seemed populated by people who for the most part either had managed to stay during the war, or returned to their villages after the war when they could find suitable shelter. The villages also appeared notable for their cohesion. These are rural communities which are working closely with the local authorities to put themselves back together, to return as quickly as possible to a normal rural life.

Annex B

NOTES, PUBLIC HEALTH

Nagorno-Karabakh: Public health issues to consider in program planning to improve the humanitarian situation

Introduction

Field Visits: In Nagorno-Karabakh (N-K), I visited the five central level hospitals: Maternity, Children's, Internal Medicine/General/Adult,Psychiatric and the TB hospital. I had the opportunity to meet with each director, some of the key staff and tour all of the different departments, as well as speaking to both the "Minister" and "Deputy Minister of Health". I also visited the diaspora-supported Arpen Center, a pre-natal clinic in Stepanakert and spoke extensively with the pediatrician running the Center about maternal health issues. I visited the MSF-France and ICRC offices, where conditions throughout N-K were discussed at length with both expatriate and local staffs. I also visited four nurses and one feldsher (equivalent to a physician's assistant) working in four northern Martekert Region health units and toured two of the health units including nearby catchment areas.

Given our mandate to look at humanitarian assistance to victims of the N-K conflict, the most expeditious way to support assistance efforts in N-K would be, where possible, to work with international organizations already on the ground (ICRC, American Red Cross, MSF-France and MSF-Belgium). Programming options are limited at the moment in part due to the few organizations on the ground. However, there is an enormous potential to make some important differences through actions as simple as making health education and medical resource materials available at different levels within the health system. The following is a guide to assist in a preliminary look at some of the health issues and current or proposed programs that could be approached on a short-term timeline (6-18 months) that fall into humanitarian assistance. Also listed are some regional reference points for drawing comparisons.

Health System Structure and Problems

Nagorno-Karabakh's health infrastructure is established and functioning despite obstacles including: outdated protocols; medical under-treatment contributing to drug resistance; lack of hygiene, deterioration of infrastructure; poor distribution or lack of medicines and despite equipment shortages. There are 252 MDs in N-K which is about 1 per 516 people, and an even larger number of nurses and physician assistants (felshers). A concern about the large number of medical personnel, is despite their abundance, it is difficult to evaluate the depth of their training and different specialization. Many medical personnel admit to feeling "out-of-date" post Soviet dissolution and after disruption of educational training by the N-K conflict. Incorporated into the health infrastructure, there is a national center for epidemiology with existent but suspect surveillance system. However, there are no established early detection or prevention mechanisms outside of childhood immunization activities.

"MOH"

Stepanakert Republican Hospital
(Obstetrics, Pediatrics, Internal Medicine, TB, Psychiatric)

6 Regional Hospitals
(plus 3 smaller hospitals)

150 Public Health Care Units (managed by nurses or felshers)
(1 per village)

Demographics

Our best estimate of N-K population is 130,000. Approximately 30,000 are

concentrated around Stepanakert. Roughly 20% of the population is under 15 years. Although it is difficult to estimate N-K wide demographic trends, in one village northern village 60% of that population was over 60 years. This is due in part to out-migration as adults in their 20s-50s have left for better employment opportunities outside N-K and with many men still in the army. The average family size is 2.3 children and despite 1998 government financial initiatives to reward families with four or more children, women with whom I spoke were inclined to wait and see progress of N-K political and economic stability before expanding the size of their families.

What diseases do medical personnel and parents report?

No current epidemics of serious infectious diseases have been seen. Diseases reported by Karabakhi medical personnel in adults, are: hypertension; CHD; TB; diabetes; skin infections and especially now in the winter months, upper and lower respiratory tract infections. Among children, respiratory infections, colds and skin diseases are reported. There is a seasonal rise in diarrhea from June to August but with no associated mortality.

For comparison:

* *These are the same diseases commonly reported in Armenia and Azerbaijan. Azerbaijan has a more pronounced problem of malaria in the southern region.*

Cost of treatment, Medicines and the Humanitarian Warehouse

The post-Soviet health care system focuses on the curative side and many diseases are treated with antibiotics. Treatments not considered "effective" by patient or medical personnel if non-injectable. These attitudes are regional, not N-K specific. Despite generous donations from the diaspora and Government of Armenia, medicines are frequently not available in government stores and are expensive in private pharmacies, when available. Part of the medicine shortage might be explained by poor storage or logistics problems. Some NGOs have estimated that 80% of pharmaceutical in N-K are currently stored in the Stepanakert humanitarian warehouse. Three possible assumptions put forward to explain the central-level blockage are: 1) N-K stock is centralized in case of war; 2) mangers justify their own employment and protect job security by not distributing; and/or 3) there is no political willingness behind drug distribution. Private foreign donations of medicines might alleviate drug shortages if pro-active planning and basic management of distribution can be improved.

In speaking to MSF-Belgium (in Yerevan), who had managed an MSF drug store in N-K during the conflict, they were resistant to tackling the humanitarian warehouse situation and viewed it as a longer-term project involving hands-on training. They

recommended contact with Belgian-based Ides, which is their sister organization that can be rapidly operational using MSF field logistics.

For comparison:

* *In Armenia, a 1996 World Bank Social Assessment found that 39.7% of "persons who were ill chose not to seek treatment because they could not afford it."*

Medical protocols

Feldshers, nurses and MDs are under-treating diseases. Evidence can be seen from medical records. As soon as patients feel improved they stop taking medicine either through lack of strict instructions to finish regimes from medical personnel, high cost of treatments, and/or a combination of these two factors. Also, registries are nicely written but are not a guarantee that medicines are taken. On entering health units, the only educational materials readily at hand were 20+ year old medial texts and if lucky, a well dog-eared copy of the MSF treatment and medications guide. This indicates a clear call to at minimum, provide at-hand medical references and health education material, and if possible, do training for prescribers of medicine.

For comparison:

* *Failure to follow protocols is common in the southern Caucasus as is the lack of medical reference or health education materials. However, NGOs serving IPD populations in Azerbaijan have been very innovative in creating or translating health educational materials (i.e. IRC just translated Where There Is No Doctor into Azeri) to make available in the camps.*

TB and other Communicable Diseases

In N-K there are an estimated 50 cases of TB per year. Another approximately 200 cases, many of which present already multi-drug resistant, would benefit from being re-treated. Both of these statistics are thought to considerably underestimate the real prevalence of TB, by possibly as much as 50-80%. However, N-K's TB problem is not dissimilar from the rest of the region.

For comparison (see attached WHO chart):

EU *14/100,000(14 cases of TB per 100,000 population)*
NIS *53/100,000*

Dagastan 80.9/100,000

The MSF-France program within the N-K TB hospital started in May of 1997 and is projected to continue through 1999 or 2000 (MSF-F has been present in N-K since 1992). The MSF-F program has involved rehabilitation of the 40 bed facility which hosts in-patients for 2-8 months of treatment. As importantly, they are training local counterparts to follow WHO protocols (including DOTS) and instituting more cohesive referral and patient follow-up systems effective throughout N-K.

There are cases of hepatitis, STDs and HIV/AIDS. It is difficult to determine their incidence. Given the medicine supply problem it is safe to assume a lack of diagnostic supplies as well as failure to follow correct medical protocols.

For comparison:

* *Azeri MOH has a draft National TB Control Program that appears to have been deadlocked since May 1997 and reportedly may not follow WHO treatment protocols.*

* *Yerevan officially reports 46-56 cases of HIV/AIDS per year and is formulating a national strategy.*

Maternal-Child Health
Including: family planning, childhood immunization, breastfeeding, pre or antenatal care, and nutrition

In N-K, the vast majority of women deliver in the Stepanakert Maternity Hospital which is the referral facility for all of N-K. In 1997 there were 1060 deliveries resulting in 986 live births. The staff tries to keep women on average 6 days for follow-up after delivery (compared to 2-3 days in Armenia). Despite an abundance of medical personnel, the maternity hospital suffers from a lack of running water, heating, hygiene, diagnostic equipment, incubators etc. A cursory look at family planning revealed that the maternity hospital also performs up to 6-7 abortions per day. Access to contraception is problematic, requiring spousal permission. IUDs and condoms are available but are also reported as expensive.

For comparison:

* *In 5 northwesterly Azerbaijani regions (Barda/Agdam/Terter/ Zanlar/ Kashkesan) 35% of rural women delivered at home (MSF-Holland 1997 survey) Relief International estimates of home births in Agcadbedi is considerably higher than 35%.*

* *Armenia official rate of abortion is 62.6 abortions per 100 live births. (UNICEF) Abortion as a method of contraception, and complications it presents to maternal health, is common in all three areas.*

Breast feeding

In N-K it appears that there is nearly universal initiation of breast-feeding but after 24 hours, thus infants lose the protective benefits of their mother's colostrum. An estimated 33% of women cease to breastfeed after the first 3 months, contrary to the internationally recommended 4-6 months. Medical personnel are aware of the breast feeding benefits but are ill trained to counsel and educate their clients about breast feeding and there seems to be little emphasis from within the health system to strengthen these activities. Again, of potential enormous benefit would be to make available educational materials such as breast feeding posters for all health units, the maternity hospital and polyclinics.

Prenatal/Antenatal Care

The main prenatal or antenatal care issues are lack of counseling, health education and diagnostic equipment. There is some concern that despite a existence of PNC and ANC care programs, utilization levels are low, especially among women with more than one child. Given the N-K authorities incentives to increase population, antenatal care is an ideal opportunity to expand past an increased birthrate to include emphasis on health of the family, mother and individual children.

For comparison:

* *Prenatal care of women outside Yerevan was 40%.*

* *A recent survey in northwest Azerbaijan discovered that "more than 3 out of 4 women received some form of antenatal care during their last pregnancy, 60% of them three times or more." Reasons for not attending PNC were that women "did not feel a need to go" or felt healthy during pregnancy. (MSF-Holland survey in 5 NW districts of Azerbaijan, 1997)*

Immunization

MERLIN, a British NGO introduced the WHO/UNICEF guidelines when they started a program in 1993 to assure N-K vaccination coverage. The "Ministry of Health" conducts two vaccinations campaigns a year, in the spring and fall. Post-war, only an estimated 3% of children haven't received vaccinations. It is not clear if the "MOH" is continuing to adhere to WHO/UNICEF immunization guidelines or reverted to the old Soviet system.

N-K vaccination coverage reported by the state epidemiological center, when compared with reported disease, demonstrates some significant inconsistencies and gaps. For example, the 1997 "MOH" reported coverage for measles is 95%, yet in 1997 there were 191 cases of measles. An independent report by Alina Dorian (American University of Armenia) estimated coverage for measles as low 37.8%. In 1996 there was an outbreak of diphtheria resulting in a "MOH" massive campaign to re-vaccinate everyone between ages 3 to 60 years. Another example is despite the reported high childhood immunization coverage rates, from late 1996-97 there were 2 clinically proven cases of polio from N-K reported in Yerevan. An illustration of a major vaccine gap is the absence of BCG vaccines in the Maternity Hospital since August 1997. This disruption is pending a donation of 4,000 dosages from the Armenian Ministry of Health.

Clearly due to the severe shortage of BCG, MERLIN is not currently assuring long term vaccination supply. If MERLIN is no longer involved or interested, MSF-France has requested funding for to evaluate the current immunization program. It is crucial to determine if coverage inconsistencies are rooted in poor cold-chains, problems in vaccine supply, over-reporting, or elsewhere in the system. Whatever the root cause, a training component should be linked to any assistance provided to improve capacity-building and pro-active planning.

For comparison:

* *Estimated 39.7% BCG coverage rate in Northwestern Azerbaijan. (MSF-Holland survey in 5 NW districts of Azerbaijan, 1997)*

Nutrition

In Stepanakert, there is some reported childhood growth stunting indicating an absence of micro-nutrients. This which may be alleviated by increasing variety in diet over the last year as more different kinds of food are available in the city. At present, there is no serious problem of malnutrition and in the northern region of Martekert where I visited a health unit (village Maghavuz) and catchment area, there was no malnutrition reported at all.

For comparison:

* *Although acute undernutrition does not seem to exist in Azeri (IDP or resident) children, there is a "fairly high prevalence of stunting", which is more pronounced among IPD children than resident children (CDC Health and Nutrition Survey, 1996). NGO-employed healthcare staff working with IDPs classify malnutrition as not acute, but chronic.*

Trauma

Parents report some signs of stress in children and cite the difficult times during the war where families were sometimes hidden in basements for a year or had to flee their homes leaving behind everything. They also remind that these events are now six years past. At present in N-K there is no early detection or referral system to catch either children or adults who evidence signs of stress, psychological or psychiatric problems.

For comparison:

* *UNICEF has psycho-social program within education system by teachers for children exhibiting signs of stress. In 1997, they did 12-14 training in border areas of Armenia.*

Psychiatric Care in N-K

Psychiatric in-patient treatment is abysmal. The psychiatric hospital might have been a livestock and storage space at one time. Psychiatric out-patient "treatment" follows unclear diagnoses and guidelines. Again, there is no counseling or early detection. MSF-Belgium has expressed a desire to assessment opportunities that might address the absence of psycho-social care, capacity building and new out-patient or alternative methods such as work therapy. In collaboration with the "MOH", they would also rehabilitate a more suitable building for use as a psychiatric hospital and are currently planning to send a consultant in February to further analyze possible mechanisms for early detection and referral system based on central consultations with traveling services.

War-wounded, invalids

A forgotten vulnerable group that was hidden to us in our N-K visit, but brought to our attention by ICRC, are the war-wounded and home-bound including paraplegics, amputees etc. The "MOH" is not prepared to cope with or even offer life-care to this

population who are a tremendous financial and emotional burden on their families. ICRC has proposed to train N-K medical personnel to institute extended-care to them in their homes.

To view the table and chart graphics listed Click below on the button:

Incidence of Tuberculosis in North Caucasus

Health Care System Overview – Nagorno-Karabagh

Annex C

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Annex D

TERMS OF REFERENCE FOR PARTICIPANTS IN THE EVALUATION OF THE HUMANITARIAN NEEDS OF N-K CONFLICT VICTIMS

(INCLUDE THE REGION OF NAGORNO-KARABAKH)

Introduction

The USAID Mission for the Caucasus plans to provide assistance to the victims of the Nagorno-Karabakh conflict. The first step of this process is to conduct an evaluation of the humanitarian needs in the areas populated by these victims.

The evaluation team will:

- Conduct an evaluation of humanitarian needs of the victims of the Nagorno-Karabakh conflict in such sectors as food, health, sanitation, communicable diseases, and shelter.

- Primary focus will be on needs of vulnerable population groups such as mothers, children, and elderly, with an emphasis on health issues.

- Conduct the evaluation in Azerbaijan and Armenia, including the Nagorno-Karabakh Region and the vicinity of N-K.

- Complete the study within two weeks.

- Consult with U.S. Embassies in Baku and Yerevan, as well as Non-Governmental Organizations (NGOs) and International Organizations (IOs) in the region.

- Assess the possibilities opened up due to recent legislation affecting Section 907 of the FREEDOM Support Act (FSA). Although Section 907 of the FSA prohibits assistance to the Government of Azerbaijan, humanitarian assistance for refugees, displaced persons, and needy civilians affected by the conflicts in the Southern Caucasus region, including those in the vicinity of Nagorno-Karabakh, may now be provided notwithstanding Section 907.

- Avoid focussing on reconstruction and infrastructure assistance, since such assistance is still prohibited by Section 907 of the FSA.

The assistance program to be designed as a result of this evaluation will be implemented through NGOs or IOs and not through local or national governments.

Evaluation Specialists

A team of no more than three (3) Humanitarian Assistance and Health (MPH) Specialists will be given responsibility for carrying out the above evaluation, working

in concert with USAID/Caucasus. A total of up to, but not more that two (2) person-weeks of effort will be the level of effort for each team member. The period of assignment will begin on or before January 17, 1998.

Scope of Work

Specific issues to be addressed include the following:

- Identification of vulnerable population groups.

- Total numbers of vulnerable population.

- Vaccination status of the populations in the area.

- Prevalence of various diseases and illnesses in the area.

- Pharmaceutical availability and affordability.

- Food availability and affordability.

- Shelter availability and suitability.

- Water and sanitation availability and suitability.

- Identification of donors and implementing agencies already providing assistance.

- Identification of specific areas not covered or which are not sufficiently covered by current donors and implementing agencies. This could include non-humanitarian areas which could facilitate the peace process.

- Preparation of an evaluation report which includes recommendations for project/activity options based on analyses of the above.

As there have been previous assessments performed in the areas outside of Nagorno-Karabakh, it is anticipated that most field work involved with this evaluation will be performed within and adjacent to Nagorno-Karabakh.

Reporting and Deliverables

Team travel and itinerary must be coordinated with USAID/Caucasus and U.S. Embassies Baku and Yerevan.

In-briefings and exit briefings will be held with USAID/Caucasus and embassy staff.

A final report containing information gathered and recommended activity options is to be provided to USAID/Caucasus before departure from the region.